# King County Deputy Sheriff Group Health Medical/Vision Plan

**Finalized April 9, 1999**
**Printed & Distributed August 1999**

# Directory

| If you have questions about ... | Contact … |
|---|---|
| • Eligibility<br>• Completing the enrollment form<br>• King County Deputy Sheriff benefit program | Employee Benefits and Well-Being at (206) 684-1556<br>Monday - Wednesday between 8:30 a.m. and 4:30 p.m.<br>Thursday between 10:30 a.m. and 4:30 p.m.<br>Friday between 8:30 a.m. and 4:30 p.m.<br><br>King County employee intranet (through the King County computer system) at http://ohrm/metrokc.gov/benefits |
| • Details about plan benefits (such as covered expenses, limitations, exclusions)<br>• Network providers<br>• Primary care providers<br>• Changing your primary care provider<br>• Out-of-area coverage<br>• Specific medical conditions or treatment<br>• Filing claims | Group Health Cooperative at (206) 901-4636 or (888) 901-4636 Monday - Friday between 7:00 a.m. and 7:00 p.m., Saturday between 9:00 am and 1:00 p.m.<br><br>Group Health Consulting Nurse Service at (206) 901-2244 or (800) 297-6877 can provide information about health concerns or care and help you understand your options. Call between 5:30 p.m. and 8:30 a.m. Monday - Friday, and all day Saturday, Sunday and Holidays. |
| • General information about Group Health (King County-specific information on benefits is not available on the Group Health web site)<br>• Network provider list for all participants (including King County employees) | Group Health web site at www.ghc.org |
| • Obtaining preauthorization for mental health care and chemical dependency treatment | Group Health ADAPT Program at (888) 287-2680<br>Monday - Friday between 8:00 a.m. and 6:00 p.m. or<br>Making Life Easier toll-free at (888) 874-7290<br>24 hours a day, 7 days a week |

*The information in this booklet is available in accessible formats by calling Employee Benefits at (206) 684-1556 (voice) or (206) 296-8535 (TDD), or through Washington State Telecommunication Relay Service at (800) 833-6388 (TDD).*

## HOW TO USE THIS BOOKLET

This booklet describes the medical coverage available to you and your family members under the Group Health Medical Plan if you are an eligible King County Deputy Sheriff employee. It summarizes the benefits, describes when coverage begins and explains how to use the plan. See your enrollment materials for details on enrollment procedures and deadlines, coverage options and related cost information.

Shaded areas throughout the booklet highlight key points for your convenience.

*This booklet uses a number of technical terms you will need to know to understand your benefits. For your reference, we've defined many terms in "Definitions" starting on page 44.*

Keep this booklet and refer to it whenever you have a question about your Group Health medical coverage. If you still have questions, contact the plan at the phone number or web site listed in the Directory in the front of this booklet. You may also call Employee Benefits and Well-Being at (206) 684-1556.

Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have questions about specific plan details, contact the plan or Employee Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue this plan indefinitely but reserves the right to amend or terminate it at any time, for any reason, according to the amendment procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

## LEARN MORE ABOUT … ON PAGE …

*Visit the King County employee intranet (accessible only through the King County computer system) at http://ohrm/metrokc.gov/benefits*

*Visit the Group Health web site at www.ghc.org for general information about Group Health. Note: For King County-specific benefit information (for example, covered expenses), consult this booklet.*

## LEARN MORE ABOUT (cont'd)… ON PAGE …

## HIGHLIGHTS

Medical coverage offers financial protection for you and your family members in the event of illness or injury.

To receive benefits from the Group Health Medical Plan:

- You make an appointment with a Group Health provider.
- You pay the $7 office visit copay at the time you receive health care services.
- The plan pays 100% for most covered services.
- The plan handles all forms and paperwork.

## WHO'S ELIGIBLE

### Employees

You are eligible for medical coverage if you are:

- A represented, commissioned employee in a regular, active, year-round position and scheduled to work at least 35 hours each week, or
- A represented, commissioned employee in a regular, active, year-round position and scheduled to work under 35 hours each week — if your position has at least 10 pay periods of uninterrupted service a year with 5 full-time work days or the equivalent of 35 hours a pay period.

### Retirees

Retirees (except LEOFF I) are not eligible for this plan.

## Family Members

*A child is your natural child, adopted child, stepchild, legally-placed foster child, legally designated ward, child placed as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.*

The following family members are eligible for medical coverage:

- Your spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with Employee Benefits and Well-Being.
- Unmarried children of you, your spouse or declared domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally that means family members you claim on your federal income tax returns).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support and maintenance. The child must have become incapacitated while covered by the plan and before age 23. You must submit proof of the child's disability for enrollment (and periodically thereafter).

*To continue an incapacitated child's coverage after age 23, contact Employee Benefits and Well-Being within 60 days of the child's 23rd birthday.*

  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan. See page 36 for details.

# COST

*The county pays the full monthly cost of coverage for you and your eligible family members under this plan.*

When you receive medical care under the Group Health plan, you pay:

- Any required copays at the time of service
- Coinsurance, if any (see definition on page 45)
- Amounts in excess of the usual, customary and reasonable (UCR) rates (see page 51 for definition)
- Expenses for services or supplies not covered by this plan.

## ENROLLING IN THE PLAN

*Your eligibility date is the first day of the calendar month after 3 months of continuous service.*

If you are a newly hired employee, you must submit a completed enrollment form to Employee Benefits and Well-Being within 30 days of your hire date. See your enrollment materials for details.

### Making Changes

Each year during open enrollment, you may change your elections.

*To add coverage during the plan year, notify Employee Benefits and Well-Being and submit a completed enrollment form within 60 days of the status change. Otherwise, you must wait until the next open enrollment period.*

You may drop family members' coverage anytime during the year. You may add family members' coverage during the plan year if any of these changes in family status occurs:

- Birth or placement of a child with you for adoption
- Placement of a foster child
- Loss of your child's eligibility under another health plan
- Death of a family member
- Marriage or establishment of a domestic partnership
- Divorce or dissolution of a domestic partnership
- Significant change in your spouse's or domestic partner's coverage attributable to his or her employment.

*Enrollment forms are available from and must be submitted to Employee Benefits and Well-Being. You'll need to file a revised enrollment form within 60 days if there is any change in your family's eligibility.*

Any change you make must be consistent with the change in family status. Here are several examples:

- If you adopt a child, you may add coverage for that child (you may not add coverage for your other children at that time)
- If your child loses coverage under your spouse's coverage, you may add this child to the county's plan
- If you get married, you may enroll your new spouse and his or her eligible children.

## WHEN COVERAGE BEGINS

*If you join during open enrollment, coverage is in effect for the entire plan year (if you remain eligible). See your enrollment materials for details.*

If you enroll during the year as a newly hired employee, your Group Health medical coverage begins on the first day of the calendar month after you complete 3 months of work. If your first day of employment is the first working day of the month for your position, that month applies to the waiting period. For example, if your first scheduled day of work is Saturday April 3 (because Thursday and Friday will be your regular days off), your coverage begins July 1. If your first day of employment is April 15, your coverage begins August 1. To be covered during these first 3 months, you must self-pay.

If enrolled by the deadline (described in "Making Changes" starting on page 3), coverage for your:

*Coverage for your family members does not start until your coverage begins and you submit a completed enrollment form listing the family members you want to cover. If your dependents are not enrolled in this plan and have other coverage — and lose that other coverage — they may be able to enroll in this plan during the year. Contact Employee Benefits and Well-Being at (206) 684-1556 for more information.*

- Newborn or newly placed adopted child is retroactive to the date of birth or placement
- New spouse begins the first day of the calendar month after you're married
- Domestic partner begins the first day of the calendar month after the date you establish a domestic partnership as indicated on the Affidavit of Marriage/Domestic Partnership.

According to Washington State law, coverage is provided for newborns under the mother's coverage for the first 3 weeks of life. To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

## PREEXISTING CONDITIONS

With the exception of transplants and growth hormones, there is no preexisting condition limit under this plan. See page 16 for more on the growth hormones waiting period and page 26 for more on the transplant waiting period.

# HOW THE GROUP HEALTH MEDICAL PLAN WORKS

## Medical Plan Summary

The following table summarizes covered services and supplies under the Group Health Medical Plan and identifies related coinsurance, copays, maximums and limitations. Please refer to "Covered Expenses" and "Expenses Not Covered" for more information on your medical benefits.

| | Group Health Medical Plan | For More Information Refer To … |
|---|---|---|
| **Annual deductible** | None | — |
| **Annual out-of-pocket maximum** | $750/person; $1,500/family | Page 8 |
| **Lifetime maximum** | None (except for chemical dependency treatment and TMJ) | See below |
| **Covered Expenses** | **Plan Pays** | |
| **Additional benefits for LEOFF I employees with occupational injuries** | 100% emergency/ambulance care; skilled nursing facility care up to 30 days/condition | Page 12 |
| **Alternative care** | 100% after $7 copay/visit | Page 13 |
| **Ambulance services** | For LEOFF II: 80%<br>For LEOFF I with occupational injuries: 100% | Page 13 |
| **Chemical dependency treatment** (up to $5,000 in plan payments in any 24 consecutive months; lifetime benefit maximum of $10,000)<br>– Inpatient<br>– Outpatient | <br><br>100%<br>100% after $7 copay/visit | Page 13 |
| **Chiropractic care** | See manipulative therapy below | Page 14 |
| **Diabetes care training** | 100% after $7 copay/visit | Page 14 |
| **Durable medical equipment, prosthetics, orthopedic appliances**<br>– Orthopedic appliances<br>– External breast prosthesis<br>– Post-mastectomy bras<br>– Nasal CPAP devices<br>– Insulin pumps<br>– Diabetic monitoring equipment | <br>50%<br>100%<br>50%<br>50%<br>100% after $5 copay/visit<br>100% after $5 copay/visit | Page 14 |
| **Emergency care** — in an emergency room (copay waived if admitted; copay waived for LEOFF I with occupational injuries) | Group Health facility: 100% after $50 copay/visit<br>Non-Group Health facility: 100% after $100 copay/visit | Page 14 |
| **Family planning** | Covered at various levels; call the plan for details | Page 15 |
| **Growth Hormones** | Inpatient: 100%<br>Outpatient: 100% after $7 copay/visit | Page 16 |
| **Home health care** | 100% | Page 16 |
| **Hospice care** | 100% up to 6 months | Page 17 |

## Medical Plan Summary (cont'd)

| Covered Expenses | Plan Pays | For More Information Refer To … |
|---|---|---|
| **Hospital care** | 100% | Page 18 |
| **Infertility** | Not covered | Page 18 |
| **Injury to teeth** | Not covered | Page 18 |
| **Inpatient care alternatives** | 100% instead of covered hospitalization or institutional care | Page 18 |
| **Lab, x-rays and other diagnostic testing** | 100% | Page 19 |
| **Manipulative therapy** (including chiropractic services) | 100% after $7 copay/visit<br>up to 10 visits/year/person | Page 19 |
| **Maternity care**<br>– Delivery and related hospital care<br>– Prenatal and postpartum care | <br>100%<br>100% after $7 copay/visit | Page 19 |
| **Mental health care**<br>– Inpatient<br>– Outpatient | <br>80% up to 12 days/year/person<br>100% after $20 copay/person, family or couple for each visit and $10 copay/group session; up to 20 visits/year | Page 20 |
| **Neurodevelopmental therapy** (for children age 6 and under)<br>– Inpatient<br>– Outpatient | <br>100% up to 60 days/condition/year<br>100% after $7 copay/visit<br>up to 60 visits/condition/year | Page 20 |
| **Newborn care** (up to at least 3 weeks as mandated by state law) | Covered at various levels | Page 21 |
| **Physician and other medical and surgical services** | Inpatient: 100%<br>Outpatient: 100% after $7 copay/visit | Page 21 |
| **PKU formula** | 100% | Page 22 |
| **Prescription drugs**<br>– Group Health pharmacy or mail order | <br>100% after $5 copay/prescription or refill; 30-day supply | Page 22 |
| **Preventive care** (including well-child checkups, routine health, hearing and vision exams and mammograms) | $7 copay/visit; 1 vision exam/person in 12 consecutive months | Page 23 |
| **Radiation therapy, chemotherapy and respiratory therapy** | 100% after $7 copay/visit | Page 24 |
| **Reconstructive services** | 100% | Page 24 |
| **Rehabilitative services** (up to 60 days or visits/condition/year)<br>– Inpatient<br>– Outpatient | <br>100%<br>100% after $7 copay/visit | Page 25 |
| **Skilled nursing facility** | For LEOFF I with occupational injuries: 100% up to 30 days/condition<br>For LEOFF II: Not covered | Page 25 |

| Covered Expenses | Plan Pays | For More Information Refer To … |
|---|---|---|
| **Smoking cessation**<br>– Sessions (limited to 1 program/year)<br>– Nicotine replacement (limited to 1 course of therapy/year) | <br>100%<br>$5 copay/30-day supply | Page 25 |
| **Sterilization procedures** | 100% after $7 copay/visit | Page 26 |
| **Supplemental accident benefits** | Not covered | Page 26 |
| **TMJ** (up to $1,000 maximum/person/year in plan payments; lifetime benefit maximum of $5,000/person)<br>– Inpatient<br>– Outpatient | <br>100%<br>100% after $7 copay/visit | Page 26 |
| **Transplants** (certain transplants/services only) | 100% | Page 26 |
| **Urgent care** | 100% after $7 copay/visit | Page 28 |
| **Vision care**<br>– Eye exams, routine | <br>100% after $7 copay for 1 exam in 12 consecutive months | Page 28 |

## How the Plan Pays Benefits

You receive plan benefits (usually paid at 100%) when your care is provided or coordinated by your primary care provider. Depending on the service, a copay may be required at the time of service.

## Annual Deductible

There is no annual deductible under the Group Health Medical Plan.

## Annual Out-of-Pocket Maximum

*If you have 3 or more family members (including yourself), each family member's covered expenses accumulate toward the family out-of-pocket maximum.*

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each year. This means once you reach your out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of that year.

Your annual out-of-pocket maximum is $750/person ($1,500/family). The following don't apply to the out-of-pocket maximum:

- Coinsurance for mental health care
- Amounts in excess of UCR rates (see page 51)
- Charges beyond benefit maximums
- Expenses not covered under the plan.

## Lifetime Maximum

There is no lifetime maximum under the Group Health Medical Plan (except for chemical dependency treatment and TMJ).

## The Network

All providers — clinics, doctors and other health care professionals who make up the Group Health network — are carefully screened. Doctors or other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. Group Health is responsible for selecting network providers.

## Selecting a Primary Care Provider (PCP)

*Your primary care provider is your personal doctor and the starting point for all your medical care.*

*Each family member may have a different primary care provider.*

Primary care providers can be family or general practitioners, internists or pediatricians. If you need a specialist, your primary care provider will arrange it.

You are strongly encouraged to choose a primary care provider from the Group Health provider directory when you enroll. A Welcome Caller will contact you soon after you enroll to help with this selection. The provider directory is updated periodically; for current information about providers, contact Group Health at (888) 901-4636.

Continuity of your care is important — and easier to achieve if you establish a long-term relationship with your primary care provider. However, if you find it necessary to change your primary care provider, call Group Health at (888) 901-4636.

## Specialists

*If you see a specialist without a referral, benefits may not be payable.*

Your primary care provider coordinates or provides your medical care. Before you see a specialist, you must have a referral from your primary care provider. In most cases, your doctor will refer you to a Group Health specialist. If you prefer to see a particular specialist, discuss this with your primary care provider who will accommodate your request if practical and medically appropriate.

When you are referred, be sure to get a copy of the referral form from your primary care provider and take it to your specialist. To allow your primary care provider to coordinate your care most effectively, check back after a specific period or certain number of specialist visits.

Sometimes a specialist wants you to see another specialist. In those instances, your specialist will discuss your care with your primary care provider who will determine if the second referral is medically necessary.

## Referrals

Your primary care provider must refer you to these health care professionals; otherwise your care may not be covered:

- Nurses
- Optometrists/Ophthalmologists (except for routine eye exams)
- Physical therapists
- Physician's assistants
- Podiatrists
- Psychologists
- Social workers
- Other professionals engaged in the delivery of health care services and licensed or certified to practice in accordance with RCW Title 18.

## Accessing Care

To receive benefits from the Group Health Medical Plan:

- You make an appointment with a Group Health provider
- You pay the $7 office visit copay at the time you receive health care services
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

*You may receive benefits when you see non-network providers in the following situations only:*

- *Emergency care*
- *Your network provider refers you to a non-network provider.*

To receive most plan benefits, your primary care provider must provide or coordinate your care. However, there are a few exceptions to this rule. You may receive these services from *any Group Health provider* — without a referral from your primary care provider:

- Manipulative therapy

- Outpatient mental health and chemical dependency services
- Routine vision exams
- Tobacco cessation programs and health promotion classes
- Urgent care
- Women's health care services (for example, maternity care, reproductive health services and gynecological care).

### Second Opinions

To receive benefits for a second opinion, you must have a referral from your primary care provider.

### If You Live Outside the Service Area

*Call Group Health for information on service areas.*

You may receive benefits if you or your covered family members are traveling outside the service area or temporarily live outside the service area and need medical attention. See page 32 for details.

## COVERED EXPENSES

*Group Health Medical Plan covers illnesses and injuries on and off the job for LEOFF I employees if the claim has been denied by Workers' Compensation. Coinsurance and copays for ambulance services and emergency care are waived for occupational injuries. For all other employees, Workers' Compensation generally covers on-the-job injuries.*

The following section describes expenses covered by the Group Health Medical Plan. To be covered, services and supplies must be medically necessary. For information on the level of benefits you receive, refer to "Medical Plan Summary" starting on page 5. Also see "Expenses Not Covered" starting on page 28.

### Additional Benefits for LEOFF I Employees

This plan covers the following services for uniformed personnel with occupational injuries if Workers' Compensation has denied the claim:

- Emergency care covered in full; no copay required

*LEOFF I refers to firefighters and law enforcement officers who are members of LEOFF Plan I.*

- Ambulance services covered in full; no coinsurance required
- Skilled nursing facility covered in full up to 30 days/ condition/person.

## Alternative Care

*You must have a referral from your primary care provider to receive benefits for acupuncture, naturopathy or massage therapy.*

Covered services include:

- Acupuncture, limited to services for conditions that meet referral guidelines
- Naturopathy, limited to conditions that meet referral guidelines
- Massage therapy, limited to conditions that meet referral guidelines

*Contact Group Health for more information on referral guidelines.*

- Licensed, participating midwives, for covered prenatal and home birth services.

## Ambulance Services

Services of an ambulance company are covered if:

- Ordered or approved by your primary care provider
- Other transportation would endanger your health, and
- Not for personal or convenience reasons.

## Chemical Dependency Treatment

*Your primary care provider can arrange for chemical dependency services or you may call (888) 287-2680.*

Inpatient and outpatient chemical dependency services are covered (see page 44 for a definition). Your primary care provider can arrange these services or — for outpatient care — you may call the Group Health ADAPT Program at (888) 287-2680 directly.

Treatment may include the following inpatient or outpatient services:

*You may also call Making Life Easier toll-free at (888) 874-7290 to be referred for mental health or chemical dependency care.*

- Covered prescription drugs and medicines
- Detoxification services
- Diagnostic evaluation and education
- Organized individual and group counseling.

## Chiropractic Care

See "Manipulative Therapy" on page 19.

## Diabetes Care Training

The plan covers diabetic care training and education.

## Durable Medical Equipment, Prosthetics, Orthopedic Appliances

Covered items include:

- Casts, splints (including TMJ splints) or braces
- External breast prosthesis and bra following mastectomy; 1 external breast prosthesis is available every 2 years (per diseased breast) and 2 post-mastectomy bras are available every 6 months (up to 4 in any consecutive 12-month period)
- Orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- Ostomy supplies
- Oxygen and equipment for its administration
- Purchase of nasal CPAP devices and initial purchase of associated supplies (you must rent the device for 1 month before purchase to establish compliance).

## Emergency Care

Emergency care is covered to treat medical conditions that threaten loss of life or limb, or may cause serious harm if not treated immediately. Conditions that might require emergency care include, but are not limited to:

- Severe breathing problems
- Unconsciousness or confusion — especially after a head injury
- Bleeding that will not stop

## Emergency Care (cont'd)

- Major burns
- An apparent heart attack (chest pain, sweating, nausea)
- Convulsions.

*You do not need a referral from your primary care provider before receiving emergency room care. See page 31 for instructions on what to do if you need emergency or urgent care.*

If you're admitted to a health care facility, you must notify Group Health within 24 hours. You may be required to transfer your care to a Group Health provider and/or Group Health facility. If you refuse to transfer, all further costs for the hospitalization are your responsibility.

In general, follow-up care directly resulting from the emergency must be received through Group Health. Non-emergency use of an emergency facility is not covered.

## Family Planning

Covered family planning expenses include:

- Family planning counseling services
- Sterilization procedures
- Voluntary termination of pregnancy
- Services to insert intrauterine birth control devices (IUDs).

*Birth control drugs are covered under the prescription drug benefit described on page 22.*

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment (such as Viagra) or diagnostic testing
- Procedures to reverse voluntary sterilization.

## Growth Hormones

The plan covers treatment of growth disorders by growth hormones.

You or your family members will not be eligible for growth hormone benefits until the first day of the 13th month of continuous coverage under this plan (unless covered under this plan since birth).

## Home Health Care

Home health care is covered if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable recurring need. Unwillingness to travel and/or arrange for transportation does not constitute an inability to leave home. If you have an approved plan of treatment, covered services include:

- Medical social worker and limited home health aide services
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative speech therapy.

The following services are not covered:

- Custodial care and maintenance care
- Private duty or continuous care in the patient's home
- Housekeeping or meal services
- Any care provided by or for a member of the patient's family
- Any other services rendered in the home that are not specifically listed as covered.

## Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse or medical social worker, physical, speech, occupational or respiratory therapist or a home health aide under the supervision of a registered nurse.

## Hospice Care (cont'd)

Hospice services are covered if:

- A Group Health provider has determined that the patient's illness is terminal and life expectancy is 6 months or less
- The patient has chosen comforting and supportive services rather than treatment aimed at curing their terminal illness
- The patient has elected in writing to receive hospice care through the Group Health hospice program
- The patient has a primary care person who will be responsible for the patient's home care and
- A Group Health provider determines the patient's illness can be appropriately managed in the home.

*A continuous home care period is skilled nursing care provided in the home during a time of crisis to maintain a terminally ill patient.*

One period of continuous home care service is covered. Continuous home care may be provided for 4 or more hours a day for up to 5 days or a total of 72 hours, whichever occurs first. A Group Health provider must conclude that the patient would otherwise require hospitalization.

The following services are not covered:

- Bereavement or pastoral counseling
- Funeral arrangements
- Respite care
- Financial or legal counseling (examples are estate planning or the drafting of a will)

- Homemaker, caretaker or other services not solely related to the patient, such as:
  - Sitter or companion services for either the patient or other family members
  - Transportation
  - House cleaning or upkeep
- Any services provided by members of the patient's family.

## Hospital Care

The following hospital care expenses are covered under the Group Health Plan:

- Drugs listed in the plan formulary (see "Definitions" on page 47 for more information on the plan formulary)
- Hospital services
- Room and board
- Special duty nursing.

## Infertility

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment (such as Viagra) or diagnostic testing
- Procedures to reverse voluntary sterilization.

## Injury to Teeth

The plan does not cover injury to teeth.

## Inpatient Care Alternatives

Your primary care provider may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital. All hospital benefit terms, maximums and limitations apply to inpatient care alternatives.

## Lab, X-rays and Other Diagnostic Testing

This plan covers diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. See "Preventive Care" on page 23 for more information on routine diagnostic tests (for example, mammograms).

## Manipulative Therapy

*You do not need a referral from your primary care provider before you see a Group Health chiropractor or osteopath.*

Manipulative therapy of the spine and extremities is covered. X-rays associated with manipulative therapy are covered when taken at a Group Health radiology facility.

## Maternity Care

Maternity care is covered if provided by a:

- Physician
- Provider licensed as a midwife by Washington state.

*While preauthorization is necessary for hospital admissions, you don't need to preauthorize the length of the stay.*

Covered maternity care includes:

- Pregnancy care
- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary for prenatal diagnosis of the unborn child's congenital disorders
- Hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies
- Complications of pregnancy or delivery
- Postpartum care

*The plan does not cover home pregnancy tests.*

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

## Mental Health Care

*Your primary care provider can arrange for mental health services or you may call (888) 287-2680.*

*You may also call Making Life Easier toll-free at (888) 874-7290 to be referred for mental health or chemical dependency care.*

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:

- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

The following mental health services are not covered:

- Biofeedback
- Custodial care
- Day treatment
- Specialty programs for mental health therapy not provided by Group Health
- Treatment of sexual disorders.

## Neurodevelopmental Therapy

This plan covers inpatient and outpatient neurodevelopmental therapy for covered family members age 6 and younger, including:

- Hospital care
- Maintenance of the patient when the condition would significantly worsen without these services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physician services
- Services to restore and improve function.

The plan does not cover:

- Implementation of home maintenance programs
- Physical, occupational or speech therapy when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

## Newborn Care

The plan covers newborns under the mother's coverage for the first 3 weeks, as required by Washington state law.

To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

## Physician and Other Medical and Surgical Services

Several other medical and surgical services are covered by this plan, including:

- Diabetic supplies such as insulin syringes, lancets, urine-testing reagents and blood-glucose monitoring reagents
- Medical care in the Group Health provider's office
- Nonexperimental implants limited to cardiac devices, artificial joints and intraocular lenses
- Outpatient diagnostic radiology and laboratory services
- Outpatient radiation therapy and chemotherapy
- Outpatient surgical services
- Outpatient total parenteral nutritional therapy
- Services performed by a Group Health provider for surgery, anesthesia, inpatient and emergency room visits
- Services performed by a Group Health provider or oral surgeon including: reduction of a fracture or dislocation

of the jaw or facial bones; excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth; and incision of salivary glands and ducts.

## PKU Formula

The plan covers medical dietary formula that treats phenylketonuria (PKU).

## Prescription Drugs

Benefits are provided for prescription drugs and other covered items (including insulin, injectables and contraceptive drugs) when you use a Group Health pharmacy or the prescriptions-by-mail program, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:

- Prescribed by a Group Health provider for covered conditions
- Filled at a Group Health pharmacy or the prescriptions-by-mail program and
- Included on the plan's drug formulary.

The plan does not cover:

- Dental prescriptions
- Drugs for cosmetic uses
- Drugs used in the treatment of sexual dysfunction disorders
- Drugs not approved by the FDA and
- Over-the-counter drugs.

To fill your prescription through a Group Health pharmacy, show the pharmacist your Group Health identification card.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your provider. The number of refills will be indicated on the label. If provider approval is required, call your pharmacy before you need to begin taking the last of your

medication. The pharmacy will need time to order your medicine and contact your provider for approval.

You may receive up to a 30-day supply for 1 copay. Generic drugs will be used whenever available. Brand name drugs will be used if necessary for health of the patient and prescribed by a Group Health provider.

### *How to Use the Prescriptions-By-Mail Program*

The first time you use prescriptions-by-mail, the mail order pharmacy must receive a prescription authorization from your doctor. There are two ways to do this:

- Obtain a written prescription from your doctor. Include this prescription, a completed prescriptions-by-mail order form, and a check or your Mastercard, Visa, or Discover information in one of our special Mail Order Request envelopes and drop in the mail. If your plan includes pharmacy coverage, pay only the amount of your copayment appropriate to the quantity you order.

- Call the Group Health Pharmacy Line toll free at (800) 245-7979 or (206) 901-4444. Give the staff member your name, your consumer number, your doctor's name and phone number, the name of the drug, and your credit card information. The pharmacist will obtain the prescription authorization from your doctor for you and mail you your order.

If you do not have a Mail Order Request form and would like to receive one, simply call the Pharmacy Line from 9 a.m. – 5 p.m., Monday – Friday.

Refills can be ordered by phone, fax or mail. Just provide your Group Health consumer number, Group Health prescription number, daytime phone number and credit card information.

## Preventive Care

The plan covers the following preventive care:

- Most immunizations and vaccinations for children

*You don't need a referral from your primary care provider before you see a Group Health provider for routine vision exams and women's health care services (maternity care, reproductive health services and gynecological care).*

- Routine physicals for adults and children (age and risk factor will determine frequency)
- Routine hearing exams (once in 12 consecutive months)
- Routine mammograms (age and risk factor will determine frequency)
- Routine vision exams (once in 12 consecutive months).

## Radiation Therapy, Chemotherapy and Respiratory Therapy

Covered expenses include radiation therapy, high-dose chemotherapy and stem cell support and respiratory therapy.

## Reconstructive Services

Reconstructive services are covered:

- To correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient's appearance. The reconstructive services must, in the opinion of a Group Health provider, be reasonably expected to correct the condition.
- For reconstructive breast surgery and associated procedures following a mastectomy, (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician, including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
  - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

For information on the level of benefits you receive, refer to "Medical Plan Summary" starting on page 5.

## Rehabilitative Services

Covered inpatient and outpatient rehabilitative services are limited to physical, occupational and speech therapy to restore function after illness, injury or surgery.

The plan does not cover:

- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available for no charge through government programs

## Rehabilitative Services (cont'd)

- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

Rehabilitative services are covered only when the plan determines they are expected to result in significant, measurable improvement within 60 days or visits. Rehabilitative services for chronic conditions are not covered.

## Skilled Nursing Facility

Covered services provided in a Group Health-approved skilled nursing facility for LEOFF I employees with occupational injuries will be provided in full up to 30 days for each condition when authorized by a Group Health provider and if Workers' Compensation has denied the claim. Convalescent or custodial care is excluded.

Skilled nursing facility benefits are not available for LEOFF II employees.

## Smoking Cessation

Services related to tobacco cessation are covered, limited to:

- Participation in 1 program a year
- Educational materials

- One course of nicotine replacement therapy a year if you're actively participating in the Group Health Free and Clear program.

## Sterilization Procedures

Therapeutic and nontherapeutic sterilization procedures are covered. Services to reverse a therapeutic or nontherapeutic sterilization are not covered.

## Supplemental Accident Benefits

Supplemental accident benefits are not covered under this plan.

## TMJ

Medical and surgical services and related hospitalizations to treat temporomandibular joint (TMJ) disorders are covered when medically necessary, subject to the maximums on page 7. Orthognathic (jaw) surgery, radiology services and TMJ specialist services, including the fitting and adjustment of splints, are also covered. TMJ appliances are covered under the durable medical equipment, prosthetics, orthopedic appliances benefit described on page 14.

The following services, including related hospitalizations, are not covered regardless of origin or cause:

- Orthognathic (jaw) surgery in the absence of a TMJ diagnosis
- Treatment for cosmetic purposes
- All dental services (except as noted above), including orthodontic therapy.

## Transplants

You or your family members will not be eligible for any organ transplant benefits until the first day of the 13th month of continuous coverage under this plan (unless covered under this plan since birth), or if the transplant is required as the result of a condition which had a sudden unexpected onset after the effective date of coverage.

The following transplants are covered:

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney

## Transplants (cont'd)

- Liver
- Lung (single or double)
- Pancreas/kidney (simultaneous).

Transplant services must be received at a facility designated by Group Health and are limited to:

- Evaluation testing to determine recipient candidacy
- Costs for the transplant surgery as well as related hospitalization and medications
- Follow-up services for specialty visits, rehospitalization and maintenance medications.

The following donor expenses for a covered organ recipient are covered:

- Excision fees
- Matching tests
- Procurement center fees
- Travel costs for a surgical team.

The plan does not cover:

- Donor costs reimbursable by the organ donor's insurance plan
- Living expenses
- Transportation expenses.

## Urgent Care

*See page 31 for instructions on what to do if you need urgent care.*

This plan covers urgent care, which is treatment for conditions that are not life threatening but may need immediate attention, for example:

- Ear infections
- High fever
- Minor burns.

Urgent care isn't treated any differently than other care. Generally, urgent care involves an office visit and is paid at the level shown on page 7.

## Vision Care

Routine eye exams are covered once every 12 months, when received at Group Health facilities.

After cataract surgery, 1 contact lens per diseased eye is covered, instead of an intraocular lens, including exam and fitting. Surgery must be performed by a Group Health provider and you must have been continuously covered by Group Health since such surgery.

Evaluations and surgical procedures to correct refractive errors not related to a disease of the eye are excluded. Complications related to such surgery are also excluded.

# EXPENSES NOT COVERED

In addition to the limitations and exclusions described in this booklet, the Group Health Medical Plan does not cover:

- Arch supports, custom shoe inserts and their fittings (except for therapeutic shoe inserts for severe diabetic foot disease) or orthopedic shoes not attached to an orthopedic appliance
- Artificial or mechanical hearts
- Benefits covered by other insurance

- Biofeedback
- Blood for transfusions
- Complications of non-covered surgical services
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism, except as required by law
- Convalescent or custodial care

## EXPENSES NOT COVERED (cont'd)

- Corrective appliances and artificial aids including eyeglasses, contact lenses or services related to their fitting, except as described in "Vision Care" above
- Cosmetic services, including treatment for complications of elective or non-covered cosmetic surgery except:
  - For reconstructive breast surgery and associated procedures following a mastectomy (regardless of when the mastectomy was performed) determined in consultation with the patient and attending physician, including:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
    - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.
- Court-ordered services or programs not judged medically necessary by the Group Health provider
- Dental care, surgery, services and appliances including treatment of accidental injury to natural teeth, reconstructive surgery to the jaw incident to denture wear, dental implants, periodontal surgery, and any other dental services, except as described in "Physician and Other Medical and Surgical Services" on page 21

- Drugs, medicines and injections not listed as covered in the plan's formulary
- Durable medical equipment such as hospital beds, wheelchairs or walk-aids, except while in the hospital
- Evaluations and surgical procedures to correct refractions not related to a disease of the eye
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, licenses, certification, registration, sports, recreational or school activities
- Experimental or investigative treatment as described on page 45
- Hearing aids or related examinations
- Hypnotherapy and all related services
- Medicines or injections for anticipated illness while traveling
- Obesity treatment, services or items, except for nutritional counseling by Group Health staff
- Orthoptic (eye training) therapy
- Over-the-counter drugs (medicines or devices not requiring a prescription)
- Physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including obtaining or continuing employment, insurance or government licensure
- Prosthetic devices
- Routine circumcisions, including newborns
- Routine foot care
- Services or supplies resulting from the loss or willful damage to covered appliances, devices, supplies and materials provided by Group Health
- Services by government agencies, except as required under federal or state law

- Sterility, infertility and sexual dysfunction testing or treatment, sterilization reversal or sex transformations
- Weight reduction, rehabilitation and behavior modification programs
- Work-incurred injury, illness or condition treatment (except in the case of LEOFF I employees who have had their claim denied by Workers' Compensation).

## SPECIAL SITUATIONS

### If You Need Emergency Care

If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your identification card.
- If you're admitted, call your plan within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, have a friend, relative or hospital staff call for you. The plan's telephone number is printed on the back of your identification card.

If you have an emergency as determined by Group Health, benefits are paid as described in the "Medical Plan Summary." Follow-up care received or coordinated through your primary care provider will be paid as any other care.

*Emergency is defined on page 45.*

*If you are a Group Health plan participant and you receive treatment at Virginia Mason Medical Center in Seattle or Eastside Hospital in Redmond it will allow the plan to coordinate your care efficiently and perhaps reduce your expenses.*

### If You Need Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention.

- For urgent care during office hours, call your physician's office for assistance.
- After office hours, call your physician's office or Group Health Consulting Nurse Service and leave your name and number; the physician on call will call you back. Depending on your situation, the physician may provide instructions over the phone, ask you to come into the

office or advise you to go to the nearest emergency room.

## If You Need Care While Traveling

*If you need care while traveling, contact your physician for guidance.*

Emergency and urgent care is covered while you travel. Routine, urgent and follow-up care is available to you as a visiting member with any Kaiser Permanente, Group Health Cooperative or Group Health Northwest provider. To find out about locations or arrange for care, call (888) 901-4636.

## If You or Your Family Member Lives Away From Home

You or your family members who temporarily live away from home (less than 90 days or as a student) may be able to access routine, urgent or emergency care at Group Health benefit levels through Kaiser Permanente, Group Health Cooperative and Group Health Northwest. To find out about locations or arrange for care, call (888) 901-4636.

## If You Take a Leave of Absence

You must contact Employee Benefits and Well-Being to arrange to continue your medical coverage during a leave of absence. Your coverage will continue (at the cost you currently pay, if any) for the periods established by your collective bargaining agreement.

## If You Leave Employment to Perform Military Service

If you leave employment to perform uniformed service (such as service in the military), you may continue medical coverage for up to the shorter of 18 months or the period of your service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Generally, you must pay the full cost of coverage. To be eligible, you must meet the requirements under USERRA. Contact Employee Benefits and Well-Being for more information. The Veterans Employment and Training Administration is also required to assist you.

*If you don't arrange to continue coverage, it will end on the last day of the month you leave employment.*

You must give Employee Benefits and Well-Being written notice when you leave employment covered by this plan to perform uniformed service. You must also give Employee Benefits and Well-Being written notice when you return after your uniformed service to employment covered by this plan.

## If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may continue medical coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of medical coverage directly to Employee Benefits and Well-Being. At the end of 6 months, you may be eligible for up to 12 more months of coverage under COBRA; see page 39 for details.

## If You Are Laid Off

If you are laid off while a participant in this plan, medical coverage for you and your eligible family members may continue for a limited time by paying the full cost of coverage. See "Continuation of Coverage (COBRA)" on page 39.

If you return to work as an eligible employee within 24 months of the date you were laid off, coverage begins the first of the month following your return. If you return after 24 months, you will be considered a newly hired employee.

## If You Die

If you die while a participant in this plan, medical coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage. See page 39.

## If You Become Disabled

If you or covered family members participating in this plan are totally disabled and your coverage ends for any reason except plan termination, medical coverage — for the disabling condition only — may be extended for 12 months at no cost to you. You may choose either this medical extension or COBRA coverage. If you elect this

extension, you forfeit your right to elect COBRA coverage and your right to convert to an individual policy.

*Contact Employee Benefits and Well-Being for more information.*

If the plan described in this booklet is terminated, the extension coverage will end on that date. Extension coverage will also end on the date you or your family members:

- Reach any lifetime maximum that may apply
- Are no longer disabled
- Become eligible for benefits under another group policy or
- Reach the end of the 12-month extension.

### If You Retire

If you retire before age 65, you may continue your coverage under COBRA as described on page 39. (Contact Employee Benefits and Well-Being for eligibility requirements).

## FILING A CLAIM

*If you're covered by Medicare and Medicare is your primary coverage, you must submit the Medicare Explanation of Benefits form in addition to the claim form and itemized bill.*

Group Health providers will file claims for you. If you need to file a claim (for emergency care for instance), request a claim form from Group Health and send it to:

Group Health Claims
PO Box 34584
Seattle WA 98124-1585

A separate claim form is necessary for each patient. When filling out the form, be sure to complete all required information, sign the form and attach the itemized bill.

## APPEALING A CLAIM

*If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 90 days from the date you filed your claim. The notice will include information required if you want to appeal.*

You may appeal a denied claim within 60 days of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid. Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate, and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days after receipt of your request.

If you have an appeal regarding the denial of benefits for investigational or experimental services, the plan will provide a written explanation within 20 working days of receiving the request for an appeal (unless the plan determines a 20-day extension is warranted due to extenuating circumstances regarding the review process).

## RELEASE OF MEDICAL INFORMATION

When you join this plan, you authorize the plan to receive and release information concerning your claims when necessary. In administering benefits, the plan may need to contact your provider or other person, organization or insurance company to obtain or release information such as medical records.

## PHYSICAL EXAM

Group Health at their own expense, may have a physician examine the covered patient when an injury or sickness is the basis of a claim. The plan may examine the patient as often as necessary while the claim is pending.

## QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In accordance with applicable law, the plan provides medical coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment, or order from a state court (including approval of a settlement agreement) or administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A medical child support order is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- A description of the coverage the alternate recipient will receive
- Each plan subject to the order.

When the county receives a medical child support order, we promptly notify you and the alternate recipient that the order has been received and what procedures will be used to determine if the order is qualified. Once the decision is made, we will notify you and the alternate recipient(s) by mail.

## COORDINATION OF BENEFITS

*In no case will you receive more than 100% of the covered expense.*

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer's group benefit plan or other group arrangement — whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, Group

Health will coordinate benefits so you receive maximum coverage (the highest allowable benefit).

*If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to Group Health.*

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
    - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
    - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody

## COORDINATION OF BENEFITS (cont'd)

- If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

Group Health has the right to obtain and release data as needed to administer these coordination procedures. For example, if the plan paid too much under the coordination

of benefits provision, it has the right to recover the overpayment from you or your provider.

## COORDINATION OF BENEFITS WITH MEDICARE

If you continue to work for the county after age 65, you may:

- Continue your medical coverage under the county plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first)
- When eligible for Medicare, active employees as well as spouses age 65 and over may elect this medical plan or Medicare as primary coverage, under the Tax Equity and Fiscal Responsibility Act of 1982. If Medicare is elected as primary coverage, this medical plan is not available. Contact Employee Benefits and Well-Being for details.

*If you have any questions about how your coverage coordinates with Medicare, contact Employee Benefits and Well-Being.*

- Discontinue this coverage and enroll in Medicare. (Federal regulations prohibit employer plans from being secondary for active participants.) If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See "Continuation of Coverage (COBRA)" on page 39 for details.

## WHEN COVERAGE ENDS

### Employees

Your medical coverage ends on the last day of the month in which you:

- Are no longer eligible as defined on page 1
- Resign, retire or are terminated.

Your medical coverage also ends on the day:

- This plan terminates

- You die.

### Retirees

Retirees are not eligible for this plan.

### Family Members

Your family members' medical coverage ends on the last day of the month in which your:

- Coverage ends
- Family member is no longer eligible as defined on page 2.

Your family members' medical coverage also ends on the day:

- This plan terminates
- Your family member dies.

## CERTIFICATE OF COVERAGE

When your coverage under this plan ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan. You will need to do this only if the other health plan has a preexisting condition limit.

## CONTINUATION OF COVERAGE (COBRA)

*To continue coverage, you or your family members must elect COBRA coverage and pay the required premium before the payment deadline.*

Continued medical coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event (described below).

## Eligibility

You and your covered family members are eligible for up to 18 months of COBRA coverage if you lose coverage because your:

- Employment ends for reasons other than gross misconduct or
- Work hours are reduced to the point where you no longer are eligible for benefits.

If you or your family member who is a qualified beneficiary is determined to be Social Security disabled at the time of one of the above qualifying events (or at any time within the first 60 days of continuation coverage), you and your family members are eligible for up to a total of 29 months of COBRA coverage. Employee Benefits and Well-Being must receive a copy of your Social Security Disability approval letter before the end of the first 18-month continuation period and within 60 days after the date of the Social Security Administration determination.

*If a second qualifying event occurs during a continuation period, your family members may continue coverage up to a total of 36 months from the first qualifying event.*

Covered family members who are qualified beneficiaries are eligible to continue coverage up to a total of 36 months if coverage ends because of any of these qualifying events:

- Your death
- Your divorce or legal separation
- The loss of dependent-child status
- Your entitlement to Medicare.

## How to Apply

*If you gain a family member while participating in COBRA, the usual plan rules for enrolling family members will apply. See "Enrolling in the Plan" on page 3 for details.*

If you and/or your family member(s) lose medical coverage as a result of termination or reduction of hours, your death or Medicare entitlement, Employee Benefits and Well-Being will notify you and/or your family member(s) of your options. If your family member will lose coverage because of divorce, legal separation or a child losing eligibility, you or your family member must notify Employee Benefits and Well-Being within 60 days of the qualifying event or the date coverage ends, if later. Otherwise, your family member's right to continue coverage under COBRA ends.

When your current coverage is scheduled to end, you and your family members will receive details about COBRA. To continue coverage, you must elect COBRA within 60 days after the later of loss of coverage because of a qualifying event or the date of your notice of eligibility to continue coverage.

### Paying for COBRA Coverage

*Employee Benefits and Well-Being will give you payment amounts and deadlines.*

You or your covered family members must make the initial payment within 45 days of the date you elect to continue coverage. Because COBRA coverage is retroactive to the day coverage ended, your initial payment must include all applicable back premiums.

You must keep paying the cost of COBRA coverage on time or it automatically ends.

### When COBRA Coverage Ends

COBRA coverage ends when you or your family members:

*COBRA coverage also ends if King County terminates the plan and no longer provides medical benefits to active employees.*

- First become covered under another group health plan after the date of your COBRA election, unless that plan limits or excludes coverage for a preexisting condition of the individual continuing coverage
- Fail to make the required payments within 30 days of the due date
- First become entitled to Medicare benefits after the date of your COBRA election
- Reach the end of the maximum COBRA coverage period or
- Are no longer disabled as determined by the Social Security Administration.

## CONVERTING YOUR COVERAGE

*Contact Employee Benefits and Well-Being for conversion forms and more details. You will not receive this information unless you request it.*

If you are no longer eligible for the medical coverage described in this booklet, you may convert your coverage. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than any amounts you currently pay for these benefits.

You will not be able to convert to the individual policy if you:

- Are eligible for any other medical coverage under any other group plan
- Have reached the lifetime maximum benefit.

To apply for a conversion plan, you must complete and return an application form to the plan within 31 days after your medical coverage terminates. Evidence of insurability will not be required.

## EXTENSION OF COVERAGE

If this medical plan is canceled, it will continue to cover any participants who are hospital inpatients on the date the plan is terminated. Coverage will end on the date of discharge or when you reach the plan maximums — whichever comes first.

## ASSIGNMENT OF BENEFITS

Plan benefits are available to you and your covered family members only. The right to payment under this plan is not subject to attachment or garnishment and the plan will not honor any assignment of benefits to anyone.

In paying for services, the plan may make the payment to you, the provider or another carrier. The plan will also make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plan also has the right to make payment jointly.

All payments are subject to applicable federal and state law and regulation. Payments made according to this section will discharge the plan to the extent of the amount paid, so that the plan will not be liable to anyone aggrieved by the choice of payee.

## THIRD PARTY CLAIMS

If you receive benefits for any condition or injury for which a third party is liable, the plan may have the right to recover the money paid for benefits. This means the plan is not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred in the recovery
- Cooperate fully with the plan in asserting plan rights — supplying any and all information and executing any and all documents reasonably needed for that purpose.

Any sums collected by or on behalf of you or your covered family members by legal action, settlement or otherwise — on account of benefits provided under this plan — are payable to the plan only after and to the extent the sums exceed the amount required to fully compensate you for your loss.

## RECOVERY OF OVERPAYMENTS

The plan has the right to recover amounts paid that exceed the amount for which the plan is liable. This amount may be recovered from 1 or more of the following (to be determined by the plan): any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any organizations or other plans. These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plan's right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

## PAYMENT OF BENEFITS

The medical benefits offered in this booklet are funded by the plan, not the county (this is not a self-funded plan). This means the medical plan is financially responsible for claim payments and other plan costs.

## TERMINATION AND AMENDMENT OF THE PLAN

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plan for any reason at any time. If the county terminates the plan, bona fide claims incurred before termination will be paid.

## DEFINITIONS

To help you better understand your medical benefits, here's a list of important definitions.

| | |
|---|---|
| **Annual Out-of-Pocket Maximum** | The most participants pay toward covered expenses each year. |
| **Brand-Name Drugs** | Trademark drugs patented for a limited period by a single pharmaceutical company. |
| **Certificate of Coverage** | A document that provides evidence of prior health plan coverage. Under the Health Insurance Portability and Accountability Act, when a participant's coverage ends, he or she is entitled to receive a certificate of health plan coverage. |
| **Chemical Dependency** | A psychological and/or physical dependence on alcohol or a state-controlled substance. (Nicotine is not state-controlled and is not eligible under the chemical |

| | |
|---|---|
| | dependency benefit.) The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered or social or economic function is substantially disrupted. |
| **Coinsurance** | The amount you share with the plan toward covered expenses. |
| **Copay** | The fixed amount you pay at the time you receive the covered service. Not all covered services require copays; see the "Medical Plan Summary." |
| **Custodial Care** | Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the patient to walk, get in and out of bed, bathe, dress, eat, prepare special diets or take medication that is normally self-administered. |
| **Dental Care** | Care of or related to the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies, drugs and devices. |

## DEFINITIONS (cont'd)

| | |
|---|---|
| **Durable Medical Equipment** | Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician. |
| **Emergency** | A medical condition that threatens loss of life or limb or may cause serious harm to the patient's health if not treated immediately. |
| **Experimental and Investigational** | A condition that exists if any of the following statements applies to it as of the time the service or supply is or will |

be provided to the plan participant. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA) and such approval has not been granted
- Is the subject of a current new drug or new device application on file with the FDA
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner intended to evaluate safety, toxicity or efficacy of the service
- Is provided under written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives
- Is under continued scientific testing and research concerning the safety, toxicity or efficacy of services
- Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning safety, toxicity or efficacy
- Is provided under informed consent documents that describe it as experimental or investigational or in other terms that indicate the service or supply is being evaluated for its safety, toxicity or efficacy
- The prevailing opinion among experts as expressed in published authoritative medical or scientific literature is that:
    - Use of the service or supply should be substantially confined to research settings or
    - Further research is necessary to determine safety, toxicity or efficacy.

In determining whether a service or supply is experimental or investigational, Group Health relies on the following sources of information exclusively:

- The plan participant's medical records

- The written protocol(s) or other document(s) under which the service has been or will be provided
- Any consent documents(s) the plan participant or plan participant's representative has executed or will be asked to execute to receive the service
- Files and records of the IRB or similar body that approves or reviews research at the institution where the service or supply has been or will be provided and other information concerning the authority or actions of the IRB or similar body
- Published authoritative medical or scientific literature regarding the service or supply, as applied to the plan participant's illness or injury
- Regulations, records, applications and any other documents or actions issued by, filed with or taken by the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services or any state agency performing similar functions.

If 2 or more services/supplies are part of the same treatment plan or diagnosis, all are excluded if 1 is experimental or investigational. Group Health consults appropriate medical staff and then uses the criteria above to decide if a particular service or supply is experimental or investigational.

## DEFINITIONS (cont'd)

| | |
|---|---|
| **Formulary** | The plan's authorized list of generic and brand-name prescription drugs approved for use by the Food and Drug Administration. |
| **Generic Drugs** | Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug. |
| **Hospice** | A private or public agency or organization with a hospice agency license that administers or provides a coordinated program of supportive care for a dying person. |

| | |
|---|---|
| **Hospital** | An institution licensed by the state and primarily engaged in diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses or in any other licensed institution where the plan has an agreement to provide hospital services.<br><br>The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or to treat pulmonary tuberculosis. |
| **LEOFF I Employees** | Firefighters and law enforcement officers who are members of LEOFF Plan I. |
| **Lifetime Maximum** | The maximum benefit amount a plan participant may receive under the plan and prior Group Health plans in his or her lifetime. This term is not intended to imply coverage is or will be available for anyone's full life. |
| **Manipulative Therapy** | Manipulation of the spine or extremities to correct a subluxation (incomplete or partial dislocation) shown by an x-ray. The subluxation identified on the x-ray must be consistent with neuromusculoskeletal symptoms related by the patient, and treatment must be within the limits of a specific documented treatment plan. Services must be provided by a state-licensed chiropractor or osteopath. Chiropractors are restricted by law to manipulation of the spine. Osteopaths are licensed to perform manipulative therapy to all parts of the body. |
| **Medical Group** | The providers to which you may be referred by your primary care provider. |
| **Medically Necessary** | Appropriate and necessary services — as determined by the plan's Medical Director or his or her designee, according to generally accepted principles of good medical practice — rendered to a participant for the diagnosis, care or treatment of an illness or injury. Services and supplies must meet the following requirements: |

- Are not solely for the convenience of the patient, his or her family or the provider of the services or supplies
- Are the most appropriate level of service or supply that can be safely provided to the patient
- Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided for preventive services
- Are not primarily for research and data accumulation
- Are appropriate and consistent with the diagnosis and, in accordance with accepted medical standards in the state of Washington, could not have been omitted without adversely affecting the patient's condition or the quality of health services
- For inpatient care, could not have been provided in a physician's office, the outpatient department of a hospital or a nonresidential facility without affecting the patient's condition or quality of health services
- Are not experimental or investigational
- The least costly of available, adequate alternatives (for an inpatient, it further means the item cannot be provided safely on an outpatient basis without adverse effect).

Group Health reserves the right to determine whether a service or supply is medically necessary. The fact that a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

## DEFINITIONS (cont'd)

**Mental Condition** — A condition classified as such by the Diagnostic and Statistical Manual of Mental Conditions, fourth edition.

**Network Provider** — A person, group, organization or facility under contract to furnish covered services to plan participants.

| | |
|---|---|
| **Open Enrollment** | The annual period when eligible King County Deputy Sheriff employees may join a plan or change plans and add family member coverage. |
| **Physician** | A physician licensed by the state in which he/she practices as:<br>• Doctor of medicine or surgery<br>• Doctor of osteopathy<br>• Physician of podiatry.<br>The Group Health Medical Plan also covers providers licensed as a physician's or osteopath's assistant, certified as a nursing assistant or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by 1 of the above physicians. |
| **Preauthorization** | Approval for medical services or supplies, *before* the patient receives them. |
| **Prescription Drug** | Any medical substance that, under the Federal Food, Drug and Cosmetic Act (as amended), must be labeled with "Caution: Federal Law prohibits dispensing without a prescription." |
| **Primary Care Provider (PCP)** | A provider under contract with the Group Health Medical Plan who provides or coordinates care for plan participants who choose him/her. |
| **Prosthesis** | An artificial substitute to replace a missing natural body part. |
| **Provider** | A person, group, organization or facility that provides medical services, equipment, supplies or drugs. This includes the following providers regulated under Title 18 of the RCW: naturopaths, acupuncturists and massage therapists. |
| **Referral** | An approved, prior authorization by a primary care provider. |
| **Service Area** | The geographic area in Washington state where the plan is authorized by the Insurance Commissioner to arrange |

for covered services through agreements with plan providers.

**Skilled Nursing Facility**

A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged.

Skilled nursing facility services are covered for employees if authorized by a Group Health provider. Convalescent or custodial care is excluded.

**Temporomandibular Joint (TMJ) Disorders**

The temporomandibular joint connects the mandible, or jawbone, to the temporal bone of the skull. TMJ disorders include those with 1 or more of the following characteristics:

- Pain in the musculature associated with the TMJ
- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

**Urgent Care**

A condition that is not life threatening but requires immediate medical attention.

**Urgent Care Center**

A facility designated by Group Health to provide care after normal business hours on a walk-in basis. Call Group Health for a list of urgent care centers.

**Usual, Customary and Reasonable (UCR) Rates**

The rates typically charged for comparable medical services provided by health care professionals in a given region with similar training and experience. UCR rates are updated every 6 months to reflect any changes due to inflation or other reasons.

## DEFINITIONS (cont'd)

**Women's Health Care Services**

These include the following health care services:

- Maternity care

- Reproductive health services
- Gynecological care
- General examinations and preventive care as medically appropriate
- Medically appropriate follow-up visits for the above services.

## PARTICIPANT BILL OF RIGHTS

*If you have questions about your benefits contact your plan as shown in the Directory.*

As a plan participant, you have certain rights, as described below.

### Dignity and Respect

You have the right to be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.

You have the right to see your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

### Knowledge and Information

*You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your physician otherwise.*

You have the right — and the responsibility — to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Medical condition and health status
- Services and procedures involved in your treatment plan

- Ongoing health care you need once you're discharged or leave the physician's office
- How the plan works (you will find that information in this booklet)
- Medication prescribed for you — what it is, what it's for, how to take it properly and possible side effects.

## Continuous Improvement

*You are a partner with your plan, your primary care provider and other health care professionals involved in your care.*

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plan
- Ask your physician to explain or give you more information about any medical advice or prescribed treatment
- Appeal any medical or administrative decisions (see "Appealing a Claim" on page 35).

## Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- Refuse treatment — as long as you accept responsibility and the consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for health care
- Refuse to take part in any medical research projects

## Plan Participant Accountability and Autonomy (cont'd)

- Be advised of the full range of treatment options (whether covered under this plan or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You also are responsible to:

*If you decide to give someone else the legal power to make decisions about your health care, that person will also have all of these rights and responsibilities.*

- Show your identification card to your physician, hospital or other provider before you receive care
- Provide your current primary care provider with all previous medical records and give accurate, complete medical information to all physicians or other providers involved in your care
- Be on time for appointments and let your physician's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let your plan know within 24 hours or as soon as reasonably possible if you receive emergency care or out-of-area urgent care
- Tell your plan and your primary care provider about planned health care, such as a surgery or an inpatient stay
- Pay all required copays when you receive health care.

## NOTES

## NOTES